NOTIFICATION OF MEDICAID/HCBS/WORKING HEALTHY SERVICES CHANGES / UPDATES

ES-3161
Rev. 7-07

TO: _____ **FROM:** _____

ADDRESS: _____ **ADDRESS:** _____

_____ _____

I. CONSUMER INFORMATION:

Name: _____

Case Number (If Known): _____ Medicaid ID #: _____

Address Change: _____ Date: _____

Responsible Person or Alternate Contact Change: _____ Date: _____

II. SRS MEDICAID INFORMATION CHANGES: (to be completed by EES Specialist or Social Worker)

☐ Review Complete: ☐ Approved / Denied ☐ Working Healthy/WORK - Temporary Unemployment Plan Needed.

Eff Date: _____ Next Review: _____ Date Last Employed _____

☐ HCBS Obligation Change: $ _____ Eff: _____ Reason for Unemployment _____

$ _____ Eff: _____

☐ Medicaid Case Close Eff: _____ Reason: _____

☐ HCBS Client Employed (possible Working Healthy/WORK eligible):

☐ Other:

Comments:

III. HCBS SERVICE CHANGES: (to be completed by Case Manager/IL Counselor/WORK Manager)

☐ HCBS/WORK Services Review: Approved/Denied _____ Effective Date: _____

☐ Level of Care Waiver Change To: _____ Effective Date: _____

☐ Monthly Cost of Services Change To: $ _____ Effective Date: _____

☐ HCBS/WORK Services Terminated -Effective Date: _____ Reason: _____

☐ Medical Bills for Obligation (Bills Attached)

☐ NF Entrance: Date Entered: _____ Facility: _____ Anticipated Length of Stay _____

Check one: ☐ HCBS-Covered Respite ☐ Temporary Care ☐ Permanent/Undetermined

☐ Other: _____

Comments:

IV. WORKING HEALTHY INFORMATION (to be completed by Benefits Specialist)

Temporary Unemployment Plan Info: ☐ Client Failed to Comply, Reason ☐ Plan Developed

Premium Repayment: ☐ Agreement Signed, Date Received _____

Other: _____

Comments:

☐ **YES** ☐ **NO**

_____

EES SPECIALIST/SOCIAL WORKER SIGNATURE DATE **ATTACHMENTS:**

_____

CASE MANAGER/IL COUNSELOR/BENEFITS SPECIALIST SIGNATURE DATE

This form supersedes IM-3161 (1-98)